MEDICAID DISEASE AND CARE MANAGEMENT
DEMONSTRATION PROGRAMS RFP
Questions & Answers - Set 2
April 28, 2005

The responses to questions included herein are the official responses by the State to questions posed by potential bidders and are hereby incorporated into the Medicaid Request for Proposals (RFP) issued March 21, 2005. In the event of any conflict between the RFP and these responses, the requirements or information contained in these responses will prevail.

PART I

1. Given the increased funding now available for the Disease and Care Management Demonstrations, will the Department consider increasing the maximum allowable cap on bids from the current $1.5M?

A. Yes. The RFP is officially modified to allow bids not to exceed $2M, instead of $1.5M, for the 24 month period of the contract.

2. Is this a grant program?

A. No, consistent with state finance law, this is a competitive procurement rather than a grant program. Bidders should be aware that the competitive procurement rules apply to this RFP, including selection based on best value for the State. All technical bids are evaluated based on the same specific criteria, and the financial bids are evaluated separately based on total bid price. Because this is a competitive bid, it is advantageous for bidders to provide the lowest possible price. See PART III-pg 9.

3. Previously the enabling legislation required that no more than one third of all demonstrations approved could serve a single social services district. Since the five boroughs of NYC are a single social services district that meant no more than one third of all approved demonstrations could be in NYC. Was that requirement changed in the final law?

A. No, there were no changes to this section of the enabling legislation. No more than one third of all demonstrations will be approved which operate in any single social services district, including the five boroughs of NYC.

4. Are surplus (spend down) Medicaid patients excluded from the demonstration?

A. No.

5. If an enrollee has a Medicaid surplus (spenddown), who is responsible for collecting the surplus? Is it Medicaid or the CMD?

A. The Medicaid program.

6. If an intervention enrollee in the CMD changes from fee-for-service Medicaid to managed Medicaid, how will the CMD be informed? [PART I-5 6.a.(5)(c)]

A. The DOH will validate active intervention enrollees provided on the monthly roster for FFS Medicaid eligibility. If for any reason, the enrollees is deemed not Medicaid eligible (loss of Medicaid eligibility, enrollment in managed care, etc) this information will be notated on the return payment roster to the contractor. The roster will be returned with indicators for payment, non-payment, and a brief explanation of non-payment, including enrollment in Medicaid managed care.

7. Are you expecting major growth in managed care enrollment during the time period this demonstration is underway?

A. Since the commencement of mandatory Medicaid managed care approximately fifty percent of the Medicaid population has remained in the FFS program. The DOH does not anticipate, nor is the DOH aware that Medicaid managed care enrollment will experience significant growth during the course of the CMD contracts.

8. How will enrollment in Medicaid managed care affect the availability of FFS recipients for CMD?

A. If an active intervention enrollee who is in the FFS program later enrolls in a Medicaid managed care plan, the active intervention enrollee will be disenrolled from the CMD.

9. Can a bidder who is also a provider of services request an intervention group that only includes recipients who are patients within the provider's network? (PART I-6)

A. Refer to Questions and Answers, Set 1, question # 81.

10. Can a proposal focus on a single care management approach as it pertains to more than one disease category? (PART I-2)

A. Yes, see PART II-8-9 and Questions and Answers Set 1, question # 19.

11. Would a CMD proposal for individuals receiving ICM/SCM for Mental Health be allowed to participate in this program if the program were to better address the recipients `physical needs? (PART I-5)

A. No, proposals to provide CMD to recipients that are already in a case management program identified by the Medicaid State Plan, such as ICM/SCM for Mental Health, would not be appropriate.

12. Would a CMD for the waiver case management program members be considered? (Part I-5)

A. No**,** a proposal to provide CMD to recipients that are already in a case management program identified by the Medicaid State Plan, would not be appropriate. See question # 11.

13. Are Medicaid eligible residents in OMH licensed community residences excluded from a demonstration? (PART I-5)

A. Medicaid recipients that are residents of OMH licensed community residences would be excluded from a CMD only if they are enrolled in a case management program identified by the Medicaid State Plan or any other excluded category.

14. Can a CMD program facilitate enrollees in maintaining their Medicaid eligibility? (PART I-5)

A. Yes. The CMD activities may include efforts to assist the recipients in maintaining their Medicaid eligibility. A Medicaid recipient may designate another person/representative to represent him/her in the renewal process. If the CMD pursues this approach, the CMD would need to assure that the recipient is willing to designate this responsibility and that all aspects of the designation are maintained. The representative would then receive the renewal form for completion and the Notice of Decision.

15. Several counties have relatively few Medicaid only CKD/ESRD members. Will we be permitted to include the dual eligible population in our proposal realizing that 90% of Medicaid members also have Medicare.

A. Yes, dual eligible recipients may be enrolled in a CMD program on or after July 1, 2006. See Questions and Answers Set 1, question # 12.

16. Am I correct in my understanding that NY Medicaid (ESRD) members go to Medicare after three months and members with dual eligibility remain with Medicaid indefinitely?

A. Medicaid recipients with ESRD would become Medicare eligible after three months. The recipient would then be a dual eligible beneficiary for Medicare and

Medicaid. The recipient would remain a dual eligible beneficiary as long as they remained Medicaid eligible.

17. Are patients on the Lombardi LTHHCP excluded from the demonstration? (PART I-5)

A. No, see Questions and Answers Set 1, question #10.

18. Can the Department provide the number of recipients in the Recipient Restriction Program by service area (and county within NYC)? (PARTI-10)

A. No.

PART II

19. Can a vendor be a prime contractor in one region and a subcontractor in another region?

A. Yes, assuming all other qualifications are met, and only one bid is submitted as the prime contractor.

20. To meet minimum qualifications, what criteria are bidders expected to use to demonstrate prior experience operating a care management or utilization review program specifically addressing persons with chronic disease?

A. Please refer to PART II-3. It is the bidder's responsibility to determine and submit evidence of prior experience that meets the minimum qualifications for this RFP.

21. We are a department of psychiatry of a university medical center that provides mental health services for Medicaid recipients. Are we eligible to bid, and under what business category do we fall.

A. Please refer to PART II-3. Confirm with your management as to whether the medical center is operated by a local government, or if not whether it is a for-profit or not-for-profit organization.

22. Is there a disadvantage in proposing a larger project?

A. Under a competitive procurement, bids which have lower bid prices, will have an advantage in regard to the financial score, which accounts for 30% of the total bid scoring. See Question and Answers Set I questions # 32 and 35.

23. May a bidder propose a population based CMD that incorporates providing both high and lower intensity care management services?

A. We are unclear what a "population-based" CMD entails. Additional details are required. However all CMDs are required to utilize the same intervention selection process defined in the RFP. See PART II-8, II-9 and Question and Answers Set 1, question #19.

24. Our organization is currently conducting a network model for provision of population health management services, including disease management services to insure that clients receive the care they need. Would the DOH consider a proposal that would include interventions targeting an entire population, not just those members for the population that have chronic disease?

A. No. The NYS 2004 legislation authorizing disease management demonstrations, and the Care Management Population section of the RFP stipulates that the target population of the demonstrations must be Medicaid-eligible persons with chronic health problems. (Attachment 1)

25. Can groups of facilities in different regions work in coordination to submit a single proposal for demonstration? (PART II-9)

A. No. Every bid must be limited to a service area which is within a single region. However, a single facility in a region may submit a proposal as the prime contractor and subcontract services from the other facilities in the group, within the same region.

26. Can a health system network of individual hospitals, or other multiple providers, submit multiple bids?

A. No, only a single bid may be submitted. The organization which manages the entire health system network may submit a single bid which involves one or more of the health care providers within the network. However, multiple bids will not be accepted from a health system network organization which has multiple providers (hospitals, clinics, etc) under the same organizational structure and fiscal management.

27. Would a health system network of individual hospitals in different regions be able to apply? (PART II-9)

A. No. Every bid must be limited to a service area which is within a single region. Further, bidders cannot submit more than one proposal.

28. What will our role be regarding the patient's present caregivers and medical personnel, including MDs? (PART II-11-15)

A. Generally it is expected that the CMD would collaborate with the patient's medical team, particularly the enrollee's physician. Also, depending on the CMD model proposed (recipient and/or provider focused) the CMD may involve collaboration with family members and caregivers to facilitate patient self management and compliance to care recommendations.

29. In the section on scalability the applicant describes the increase in services. Where in Financial Attachment 8 is the monetary value of the increase described? (PART II-9)

A. Scalability is reported as part of the technical proposal. The financial proposal will not be evaluated for scalability. The bidder is not to propose a price for expanding or extending operations of the demonstration, only the price for the initial contract term. The DOH may determine to expand or extend a demonstration and would then fund such changes in addition to the initial contract if approved by the Office of the State Comptroller.

30. What assumptions do you want disclosed other than number of enrollees, per member per month rate and start up cost? (PART II-6)

A. Any key assumptions upon which the bid price is based that may be helpful to the Financial Evaluation Team in understanding and evaluating the proposal. Assumptions will not alter the bidder's responsibilities or limit the scope of this project.

31. Please clarify "Provision of urgent and emergent care management services based on DOH approved policies and procedures." (PART II-17)

A. Each CMD must have in place policies and procedures approved by the DOH to manage a medical emergency and/or perceived emergency for intervention enrollees in need of urgent or emergent health care. The determination may be made by the CMD via direct enroll contact (i.e., telephone or face to face) or via data analysis. The contractor will also be responsible to have an introductory emergency disclaimer message for all callers.

32. Is it necessary to use the State's IRB? May an applicant use their own? (PART II-22 and Appendix G)

A. Yes, selected bidders must use the State's IRB application included in Appendix G. Appendix G also includes the IRB review protocols and a checklist of materials that must be submitted with the application to the State's IRB.

33. Can the DOH provide additional information about the DOH IRB approval process and timing? (PART II-22)

A. Only bidders who are selected as contractors will need to submit the IRB application forms and supporting documentation required by the IRB. IRB approval, if required, must be completed prior to program implementation. The bidder should include the IRB application process and ongoing informed consent protocols in their proposal work plan and timeline for the implementation period. The majority of IRB reviews are completed within a period of three to ten days. General requirements for informed consent can be found in 45CFR 46.116 and Article 24-A Sec. 2442 of the New York State Public Health Law.

PART III

34. When do you anticipate awards will be made? The RFP indicates that the programs can begin four months after the contracts are signed. Does the Department have a specific date in mind for being implementation? (PART III-1)

A. Depending upon the time required for bid evaluation, the CMD programs' contracts are expected to begin on October 3, 2005, with an implementation period of four months thereafter.

35. Could you describe what data you would make available to potential bidders who have submitted a letter of intent? Is it possible to get data for specified zip codes in NYC(less than a borough or county)? Is it possible to get data on Medicaid spending as well as utilization? Is it possible to get de-identified patient-level data, or will it be aggregated? (PART III-3)

A. Please refer to Questions and Answers Set 1, questions #55-58. No, the data will not be available by zip codes.

36. Do we have to submit a Letter of Intent to obtain Medicaid aggregate data?

A. Refer to PART III-3.

37. What is the pre-selection process? Will site visits be conducted?

A. There is no pre-selection process, for information on the pre-screening process please refer to PART III-10. Site visits will not be conducted; however, the Department reserves the right to request those bidders who are being considered for selection to provide oral presentations in order to clarify their bids. PART III-9.

38. Would the DOH consider a separate implementation period for dual eligibles?

A. No. There is only one implementation period; however dual eligible enrollees may be phased into the existing CMD after July 1, 2006.

39. Would the state consider awarding two demonstrations to cover the same district or region, in whole or in part?

A. Yes, please refer to PART III-12 and Questions and Answers Set 1, question #3.

40. If chosen as a site, are the terms and conditions of the contract subject to negotiation?

A. The contract terms included in Section IV, and all standard appendices, are applicable to all contractors selected under this procurement. As noted in PART III-1, Section B.2, the contract will provide for good faith negotiations of terms if and when any material changes in scope should occur. See PART IV of the RFP for the specific contract provisions.

Attachments

41. Will any claims data be provided to enable agencies to understand who the population is and why they need services? This information is needed to design an effective clinical program. (PART III-3, and Attachment 2)

A. No. Claims data will not be provided to bidders for preparation of their proposal submission. See Questions and Answers Set 1 questions #55-59 for information on Medicaid aggregate data available for bidders.

42. In Attachment 2 are the totals given for patients who are difficult or expensive to manage or have they been randomly selected?

A. The Medicaid eligibles identified all met specified utilization criteria used to define the various chronic disease populations included in Attachment 2.

43. What are the main reasons that the recipients in Attachment 2 are not enrolled in Medicaid managed care?

A. Due to a variety of factors recipients may remain in FFS Medicaid, i.e. in some counties recipients may still only chose to join or not join a managed care plan if one is available, not all counties have mandatory Medicaid managed care and in counties with mandatory managed care there are several exempt categories for recipients who are not required to enroll.

44. What does the Medicaid Health Care Information includes? (Attachment 4, Page 1, Stage 2,a.)

A. The Medicaid data will include standard information that is available from the adjudicated Medicaid claims including service dates, diagnostic codes, procedure codes, providers, provider types, service categories, and other pertinent information. See Questions and Answers Set 1 question # 83.

45. Is the Department open to selecting a control group from another service area (to avoid setting up different standards of care for patients treated by the same providers)?

A. No. The research design is a 2-group pre/post test. Both control and intervention groups will be drawn from the same population of prospective intervention enrollees, according to the contractor's approved selection criteria for the chronic disease population and region.

46. How are you breaking out the intervention and control groups? What is the proportion of eligible people who will be assigned to the program and control groups? What is the randomization model?

A. See Questions and Answers Set 1, questions # 38 and 39. The control group will be assigned via a weighted, stratified random selection process (using the disease severity scale applied by the contractor).

47. Will Medicaid assist us in tracking patients who have moved and patients we seek to discontinue from equipment at the end of the project? (Attachment 4)

A. DOH expects that the contractor will be following movements of active intervention enrollees due to the close contact afforded by their CMD intervention program. If an enrollee moves out of the service area of the CMD, the contractor may or may not choose to continue to serve the particular enrollee.

It will be the responsibility of the contractor to obtain any equipment that has been provided the enrollee (i.e. electronic monitoring) that the Medicaid FFS program has not provided reimbursement for under the terms of the CMD program and its contract.

48. Assuming that outcomes will be measured by a decrease in high cost utilization, how will the CMD be notified of progress and how often? (Attachment 5)

A. The contractor will receive monthly Medicaid claims data, including pharmacy, on all active intervention enrollees.

49. For calculation of cost savings, which recipients will be included in the intervention group? Only those actually enrolled in the contractor's program? (Attachment 5)

A. Yes. Please refer to Questions and Answers Set 1, questions # 86 and 93.

50. If not using standard measurement methodology how will you compare our results to those of other projects?

A. DOH will be using standard measurement methodology. See Questions and Answers Set 1 questions #86 - 96.

51. How will billing be completed? (Attachment 7)

A. On a monthly basis, the contractor will submit a list of names and Medicaid CINs for each intervention enrollee as of the last day of each month for whom the contractor is billing the PMPM. The DOH will verify the accuracy of Medicaid enrollment status of the intervention enrollees, and return a confirmed list to the contractor. The contractor, upon receipt of the approved list, shall submit their invoice indicating the approved number of enrollees, the approved PMPM rate, and total amount due.

52. How long will it take to get paid?

A. Invoices will be paid in accordance with State Finance Law.

53. Please clarify TP-1 Form. Who is the client? Is it the State Medicaid Program? (Attachment 8)

A. The "client" is the organization that the bidder is using as a reference in order to confirm to the DOH that the bidder has previous or current experience as required by the RFP. A State Medicaid Program could be a client if the bidder has previously provided disease and care management services to that Medicaid program. Bidders must submit reference information regarding all State Medicaid Programs for which they may have provided care or disease management services. See Questions & Answers Set 1, question #28 and the Official Modifications to the RFP section.

54. On TP-1 Item 4: What final reports are you looking for? (Attachment 8)

A. DOH is requesting final evaluative program reports including health outcomes and documented cost savings as a result of the care and disease management services provided by the bidder to the referenced clients.

55. TP-3: If key personnel are already employees of the applicant organization and have gone through the organization's normal employment process, do we need to provide 3 additional references? (Attachment 8)

A. Yes.

General

56. Are there any conflicts if people are already under care within the agency?

A. Yes, if patients are already being managed in a care or disease management program of that agency or any other care or disease management program, they would not be eligible for enrollment in a CMD.

57. We are a certified home health agency. If chosen as a demonstration site, is the agency held to CHHA regulations for OASIS and discharge?

A. A NYS certified home health agency would be required to meet all federal and state regulatory requirements including collection and submission of OASIS (Outcomes and Assessment Information Data Set) and discharge for any patient admitted to that CHHA and receiving skilled home care services from health care professionals such as registered nurses, physical and occupational therapists, social workers; etc.

However, if intervention enrollees in a CMD provided by a CHHA or a licensed agency of that CHHA, were not admitted to the CHHA for skilled health care services and were receiving care and disease management services provided by persons not governed by Public Health Law, section 3612, such as community health educators, the CHHA may not be required to follow all state and federal regulations. All such determinations for governance under federal and state regulations for CHHAs would be determined on an individual basis dependent upon the CHHA's proposed CMD.

58. If we are a certified home health agency (CHHA) applying to be a demonstration site, are we held to the CHHA regulations for certificate of need? Since our license is limited to one county, can we go beyond that for the CMD?

A. Please refer to the above question #46. Due to a long standing needs issue, new CHHAs and expansion of existing CHHAs into new counties is currently prohibited. An existing CHHA will be required to serve only patients in their approved service area.

59. Please confirm that submitting a bid or being awarded a contract from this procurement does not prohibit or disqualify bidders from participating in future (or existing) DOH grants or procurements. If submitting or being awarded a bid does prohibit vendors from being selected in existing or future DOH procurements - please specifically identify the procurements (or type of procurements) that would be so prohibited.

A. We are unaware of circumstance whereby a bidder would become ineligible for another DOH contract based on being awarded a CMD contract. However, the bidder should confirm with other responsible DOH administrative offices regarding the requirements under other DOH procurements or grants.

However, funding from this CMD procurement may not be used to duplicate, add on or expand upon other grants or awards, including the Telemedicine Demonstration Program RFA issued by the DOH Division of Home and Community Based Care. The Medicaid CMD programs are meant to be stand-alone demonstrations that are not combined with other programs.

Appendices

60. If the enrollee receives Medicaid fee-for-service services through another organization, how does the CMD obtain information from the other organization in compliance with HIPAA regulations? (Appendix H and N)

A. When the contractor enrolls a Medicaid recipient, that contractor should have the recipient sign an authorization to release Medicaid Confidential Data/Protected Health Information from their provider.